Commonwealth of Virginia Health Benefits Program
Extended Coverage Enrollment Form

To enroll or make eligible changes, complete the applicable parts of this Extended Coverage Enrollment Form, and **return to the appropriate agency Benefits Administrator**. See the Benefits Administrator or the Department of Human Resource Management's (DHRM) Web site at **www.dhrm.state.va.us/hbenefit.htm** for complete Extended Coverage information.

PART A: Enrollee Information

PLEASE PRINT

Name _____ Social Security Number _____-_____-_____
First Name M.I. Last Name

Address _____
Street City State Zip

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex: ☐ Male ☐ Female Date of Birth _____
MM/DD/YYYY

PART B: Reason(s) For Submitting Enrollment Form

I. ☐ **Enroll in Extended Coverage** (Initial Enrollment) Date Of Qualifying Event _____

Qualifying Event (Check one)

☐ Termination of Employment
☐ Divorce
☐ Reduction in Hours (includes leave without pay and VSDP long-term disability)
☐ Loss of Dependent Eligibility
☐ Death of the Employee

Once enrolled, you may change your plan and type of membership during the annual Open Enrollment or within 31 days of a consistent qualifying mid-year event which permits an election change outside Open Enrollment.

II. ☐ **Open Enrollment Change**

III. ☐ **Military Leave Without Pay**

IV. ☐ **Changes Outside Open Enrollment**

Dependent(s) affected by membership change:

Add Dependent (Name) _____

Remove Dependent (Name) _____

Qualifying Mid-Year Events Date of Event _____

Change In Your Marital Status
☐ Marriage
☐ Divorce
☐ Death of spouse

Change Affecting Your Family Members
☐ Birth
☐ Adoption, placement for adoption*
☐ Covered child loses eligibility (exceed plan's age limit, marries, becomes self-supporting, etc.)
☐ Court order to cover child
☐ Permanent custody of a child
☐ Gains eligibility for Medicare or Medicaid
☐ Loses eligibility for Medicare, Medicaid, or another government-sponsored plan
☐ Spouse or covered child begins employment

Change Affecting Your Family Members *(continued)*
☐ Spouse or eligible child ends employment
☐ Spouse or child begins leave without pay
☐ Spouse or child ends leave without pay
☐ Death of a covered child
☐ Department of Social Services (DSS) order to cover a child
☐ Spouse or eligible child switched from full-time to part-time employment or vice versa

Changes Due to Special Circumstances
☐ Annual enrollment or change allowed under another employer's plan
☐ Permanently moves in or out of plan's service area (plan change only)
☐ Special Enrollment under HIPAA
☐ Permanent change in residence affecting eligibility for coverage
☐ A court has required that another party cover your children

*The Department of Human Resource Management must review all pre-adoptive placements to verify eligibility.

PART C: Health Coverage

I. TYPE OF MEMBERSHIP (Check one)

☐ Single ☐ Enrollee Plus One ☐ Family

Is this a change in membership? ☐ Yes ☐ No

II. HEALTH PLAN

Be sure to use a provider or facility that participates in your plan's provider network. Contact the plan or visit its Web site for a list of providers. For services outside Virginia, members of the Virginia Plan should use the Anthem BlueCard PPO network. Consult your Member Handbook for additional information.

(Check One)

Self Funded Statewide Plans

Administered By Anthem Blue Cross and Blue Shield

☐ COVA Care (includes basic dental)
☐ COVA Care with Out-of-Network
☐ COVA Care with Expanded Dental
☐ COVA Care with Out-of-Network and Expanded Dental
☐ COVA Care with Vision, Hearing and Expanded Dental
☐ COVA Care with Out-of-Network, Vision, Hearing and Expanded Dental
☐ Medicare Coordinating Plan: Plan Name _____

Regional Fully Insured HMO (Northern Virginia)

☐ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO
**Note: Kaiser plan members must select a primary care physician.*

III. FAMILY MEMBERS TO BE COVERED (list all)

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF= other female child* OM=other male child*

Name (include last name if different) PLEASE PRINT	Birthdate MM/DD/YYYY	Social Security Number	Relationship Code
SPOUSE			
CHILDREN			

If you need more space, list additional children on a separate sheet of paper and attach to this Form.

*Attach explanation. Eligibility must be verified by your Benefits Administrator.

IV. PAYING PREMIUMS

Your premium is always paid on an after-tax basis. Monthly Premium Amount $_____

PART D: Certification

AUTHORIZATION: I authorize any medical professional, medical care institution, or any other provider of health care services or supplies to furnish to the plan, Department of Human Resource Management (DHRM) or its agents, information concerning services or supplies provided to me, or persons covered, for the purposes of review, investigation, or payment of a claim. I hereby authorize the plan, DHRM or its agents, to review and/or examine my records as necessary in auditing and administering the State Health Benefits Program. I understand that I am entitled to a copy of this authorization, which is available upon request to me or my representative. This authorization is valid for the duration of coverage.

ENROLLEE STATEMENT: Payment of premiums is based on a monthly amount and partial payments are not allowed. Once enrolled, I understand that changes may only be made at Open Enrollment or with certain qualifying mid-year events (see Part B) when the changes are consistent with the events. I further understand that notice of cancellation of coverage does not relieve me from my obligation to pay the entire monthly premium for any month of coverage already begun. I am aware that the Commonwealth reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that non-payment of premium will result in cancellation of coverage.

CERTIFICATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the State's Health Benefits Program and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name _____ Social Security Number _____

SIGN HERE _____ Date _____

Agency Approval/Verification

Number of months for Extended Coverage: _____

I certify that I have reviewed this Extended Coverage Enrollment Form and that it is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date Received _____ MM/DD/YYYY

Print Name and Title_____ Phone No._____

Agency Name _____ Agency No. _____ Effective Date _____ MM/DD/YYYY